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Mental Health and the Law: Where Necessity Is the Mother of Invention (Patent Pending)

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Foreword: Mental Health and the Law: Where Necessity Is the Mother of Invention (Patent Pending)

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The evolution of mental health treatment, and the law that governs such treatment, is much like Darwinian evolution itself: no one knows for certain whether the outcome will make us embarrassed about our ancestors or whether our descendants will be embarrassed about us. Despite our best attempts to balance patient rights and the practicalities of day-to-day practice, someone, somewhere usually winds up feeling put upon and put out. And, often, the clinicians feel that the lawyers have the final say, and no one is happy. Believe me, I know—I have been a psychiatrist for thirty years, with the past twenty spent in public mental health as a treating clinician and, more recently, as the Assistant Medical Director at a state operated inpatient psychiatric treatment facility. I wish that I could say that my career in the public sector has been filled with nothing but endless fascination and professional satisfaction, but that would not give the complete picture, particularly with regard to the reasons for this symposium: to examine where we have been, where we are at present, and the future direction we need to take in the area of mental health law.

While many of our "inventions," not to mention our innovations, in crafting treatments for the mentally ill are fraught with legal landmines at every step, it is probable that the intentions of the "inventors"—the psychiatrists, the lawyers, and the legislators—are the same: compassionate and effective treatment of those with a mental illness where the rights of those in treatment and of those being considered for treatment are zealously and

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unyieldingly safeguarded by mental health laws that reflect sound public policy that serves the best interests of the individual and of society.

Doctors Thomas Gutheil and Paul Applebaum, in the foreword to their seminal text, *Clinical Handbook of Psychiatry & The Law*, note a commonly voiced frustration of mental health practitioners, especially clinical psychiatrists: "I'm a clinician, not a lawyer. All I want to do is help people. Why doesn't the law just let me do my job?"[1] However, the authors continue with the cautionary advice:

> Decry it as they may, mental health professionals of every theoretical orientation and in all types of practice settings can no longer afford to be ignorant of the law. Court decisions, statutes, and administrative regulations have so affected clinical practice that few everyday decisions can be made without awareness of the legal rules governing such actions and, equally important, of the effect that those rules may have on the treatment of the patient.[2]

In my daily life, both as a treating clinician and as Assistant Medical Director at our state hospital, it is important to remain mindful of mental health law in professional interactions with our patients and, as well, in relationships with our clinical treatment staff. Specifically, from the prescribing of psychotropic medication (sometimes on an involuntary basis) for those suffering the ravages of mental illness, to consulting with our staff about the legal ramifications and current code governing treatment approaches to a particular patient, it is critical that clinicians possess a thorough, working knowledge of the law (or know someone nearby who does) as it pertains to our day-to-day professional lives and behaviors.

For the mental health professionals who work in state operated inpatient psychiatric facilities, the major legal concerns relate to the following general areas: emergency (involuntary) admission to the hospital, civil commitment requirements and procedures, documentation requirements and standards for involuntary administration of medication in short term emergency situations, the criteria and procedures for court ordered involuntary medication administration when necessary, and the needs of mentally ill individuals whose behavior overlaps with the criminal justice system. The statutes governing what are essentially medical decisions and medical practices are extensive and detailed, and seem vague and contradictory to non-legal professionals attempting to interpret and implement them. Frequently,

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1. PAUL S. APPELBAUM & THOMAS G. GUTHEIL, CLINICAL HANDBOOK OF PSYCHIATRY & THE LAW, at viii (4th ed. 2007).

2. *Id.*

clinicians feel frustrated by the impression that these laws are never concerned with the many vagaries of treatment and its outcome—nor should they be, you might be thinking. And you would be correct. It is the responsibility of the treating professionals, not of the legislators, to implement the laws in ways that effectuate the appropriate and effective psychiatric treatment of patients, motivated by compassion and concern that ensures respectful treatment. This, in turn, insures that patients' dignity and legal rights are at all times maintained and guaranteed. To do less would be unconscionable and would violate not only the various mental health laws we are bound to incorporate into our practices but the personal and professional values we all hold near and dear.

The legal aspects of treating someone who has a mental illness have become progressively more complex as a result of our increasing knowledge about the diagnosis and treatment of mental illness and as a result of an evolving legal code that is ever mindful of the fiduciary responsibility that is the professional duty of the court and its officers. In Illinois, the civil statutes governing treatment of those with a mental illness have attempted to strike a balance between the protection that must be afforded to society from the potentially harmful behaviors of a mentally ill person and the civil rights of the person who may be a threat to others or to himself. Please bear in mind, however, that the vast majority of persons with a mental illness are not a danger to others or themselves.

As a prerequisite to involuntary hospitalization for psychiatric treatment, the Illinois Mental Health Code requires that details of an individual's behavior and/or mental state be described by a concerned family member or citizen on a Petition for Involuntary Admission, which sets forth the alleged aberrant behaviors or statements that are causing others to be concerned or alarmed.[3] The petition also must list witnesses that may be called into court to confirm the allegations.[4] The individual who is the subject of the petition usually is taken into custody by the police for transport to the emergency department of a local hospital, to a local community mental health center, or, if necessary, to a local jail. It is there that a Qualified Professional (any physician, including a psychiatrist, a clinical psychologist or social worker, or a Qualified Mental Health Professional not in one of the preceding groups)[5] performs a brief psychiatric/psychological examination that either confirms or fails to confirm the allegations described in the petition. If the allegations in the petition are confirmed, a Certificate of Examination is completed by the examining professional, which, in combination with the petition, are the two legal documents necessary for that indi-

3. 405 ILL. COMP. STAT. 5/3-601(b)(1) (2005).
4. 405 ILL. COMP. STAT. 5/3-601(b)(2) (2005).
5. 405 ILL. COMP. STAT. 5/3-602 (2005).

vidual to be admitted to an inpatient psychiatric treatment facility,[6] either at a local hospital or at one of nine psychiatric hospitals operated by the State of Illinois, depending on the area in which the individual resides.

The patient is admitted on an emergency (involuntary) basis and must be examined within twenty-four hours by a licensed psychiatrist[7] who completes another Certificate of Examination that confirms the allegations set forth in the petition and first certificate.[8] One would logically assume that once the procedure for admission has been faithfully followed and the person is now an inpatient, treatment would commence. Unfortunately, one would be wrong. Admission is only half, or maybe even a quarter, of what is required to actually receive treatment after admission. The questions of involuntary commitment and involuntary treatment must be addressed if patients do not consent to such.

After admission, patients are retained in a treatment unit for assessment of the possible need for court-ordered commitment for continued treatment. Of course, an individual may request to sign an Application for Voluntary Admission at any point during the process, including when first examined,[9] which would negate the need for a court hearing. Voluntary admissions are for an indeterminate length of stay for treatment.[10] It is the patient and the treatment "team" (comprised of the psychiatrist, who leads the team; the nurse, psychologist, and social worker; and various rehabilitation specialists) who together determine when the patient is ready for discharge back to their home or to an appropriate residence in the community if the patient was homeless at the time of admission.

When patients do not consent to voluntary treatment, a court hearing must be held within five business days of admission to determine whether the person is subject to continued involuntary retention in the hospital.[11] If so, the individual may be confined for a period up to ninety days, after which a new petition and certificate must be completed if the person is determined to need further time in the hospital in order to recover sufficiently to return to their community.[12] I would be content if commitment hearings involved only pleasant and helpful interactions between physicians, lawyers, and judges. Sadly, such cooperation, at least the pleasant and helpful

6. *Id.*

7. 405 ILL. COMP. STAT. 5/3-610 (2005). Facilities may impose stricter timeframes for examination by a psychiatrist than those required by statute. For example, the facility at which this author is employed requires that patients be examined by a psychiatrist within one hour of admission.

8. *Id.*

9. 405 ILL. COMP. STAT. 5/3-400 (2005).

10. The average length of stay for voluntary patients is ten days at the hospital at which this author is employed.

11. 405 ILL. COMP. STAT. 5/3-611 (2005).

12. 405 ILL. COMP. STAT. 5/3-813(a) (2005).

variety, is the exception rather than the rule. No one, it seems, has ever really liked the manner in which commitment hearings are conducted. The patient feels that the doctor is his adversary, the doctor feels that the lawyer is everyone's adversary, and—at least in this clinician's estimation—the judge silently wishes that everyone would get their act together and do the right thing. Sometimes they do, but usually they do not; instead, each blames the other, and no one is pleased with the result. Patients are found "not subject to involuntary treatment" and discharged because it is the lawyer's job to argue for discharge if the patient voices that desire. However, in many instances, the psychiatrist believes the patient would benefit from continued treatment and, unfortunately, patients discharged after a commitment hearing have a relatively high rate of recidivism—often within a short period of time after the court-ordered discharge. It is a deeply flawed process, and no one seems to know how to fix it.

Even in the instances where a patient is court ordered to inpatient hospitalization, the next hurdle to overcome is convincing an unwilling patient to accept treatment. While the recently revised Mental Health Code expanded the circumstances under which individuals may be subject to involuntary admission to a psychiatric treatment facility,[13] it did not provide for a corresponding expansion of legal criteria for needed treatment.[14] If a patient needs psychiatric medication to treat his mental illness but refuses, such medication can be administered only under duress (involuntarily) if certain criteria are met: dangerousness to self and/or others as evidenced by the presence of certain behaviors and certain comments that the patient is verbalizing.[15] And then, such treatment must be documented each and every time an involuntary medication is administered.[16] Emergency medication may not be administered for more than three consecutive days (excluding weekends and holidays) without petitioning for a hearing for court-

13. 405 ILL. COMP. STAT. 5/1-119 (Supp. 2007) (effective June 1, 2008) (expanding the definition of "person subject to involuntary admission" to include a wider range of behaviors and actions that can potentially make an individual subject to involuntary psychiatric hospitalization).

14. *See, e.g.*, 405 ILL. COMP. STAT. 5/2-107 (Supp. 2007) (setting forth detailed criteria for involuntary administration of medication in emergency situations when necessary to guard against harm to the patient or others in the absence of medication); 405 ILL. COMP. STAT. 5/3-608 (2005) ("The respondent shall be informed of his right to refuse medication and if he refuses, medication shall not be given unless it is necessary to prevent the respondent from causing serious harm to himself or others.").

15. 405 ILL. COMP. STAT. 5/2-107(a)-(b) (Supp. 2007); *see also* 405 ILL. COMP. STAT. 5/2-107.1(a)(4)(A)-(G) (Supp. 2007) (setting forth specific criteria that must all be met before a patient may be found subject to involuntary medication).

16. 405 ILL. COMP. STAT. 5/2-107(c) (Supp. 2007).

authorized continuation of involuntary treatment,[17] which, if granted, is for a period not to exceed ninety days.[18]

Depending on the jurisdiction in which the facility is located, such requests may be easily obtained or are almost never obtained in spite of what seem to be clear and unambiguous legal standards for completion of the petitions. It is an understatement to say that, from the clinician's perspective, the process of granting or denying petitions for involuntary medication appears capricious and often fails to recognize the legitimacy of the need for treatment, allowing the right to refuse treatment greater latitude than the right to receive treatment, often to the patient's detriment.

However, there have been noteworthy positive developments in our mental health system. One fairly recent "invention" in the treatment system represents a step toward improving a heretofore neglected, but nonetheless serious, need of certain mentally ill individuals who commit crimes. Historically, such persons were simply processed through the criminal justice system with little attention given to their mental illness or how it may even have contributed to their criminal behavior. However, since 2005, mentally ill individuals who commit certain crimes within the Seventeenth Judicial Circuit are referred to a specialized court in the circuit: this court is known as the Therapeutic Intervention Program, or TIP. Essentially, the purpose of the Therapeutic Intervention Program is to stop "the revolving door of crime and mental illness" by collaborating with the local community mental health center to "work with offenders who have a serious mental illness, to provide improved access to treatment and community services in an effort to reduce future criminal activity and incarceration in the jail."[19]

The Therapeutic Intervention Program has become an important and indispensible part of the compassionate and rational treatment of individuals with a mental illness. In an era of drastically declining resources at all levels of government-funded programs, the Therapeutic Intervention Program becomes increasingly important in the interface between the criminal justice system and the mental health treatment system.

Mental health treatment in Illinois, and its interaction with the legal system, is a continually evolving process, with professionals in all aspects of the process attempting to provide input and insights that will improve the outcome for the recipients of our services. The legal scholars and mental health professionals who contributed to this symposium reflect the leading issues and concerns of those practitioners whose professional duties, and

17. 405 ILL. COMP. STAT. 5/2-107(d) (Supp. 2007).

18. 405 ILL. COMP. STAT. 5/2-107.1(a)(5) (Supp. 2007).

19. Seventeenth Judicial Circuit Court of the State of Illinois, http://www.illinois17th.com/index.php?option=com_content&task=view&id=15&Itemid=33 (last visited Apr. 25, 2009).

perhaps even personal experiences, bring them into that intimate interface between psychiatry and the law. Knowledge, therefore, of current mental health law and current mental health practice is essential if those who are subject to both will be treated with the compassion and care, and the dignity and respect that they deserve as our fellow citizens and, most important, as our fellow human beings.